Nationally Ranked. Locally Trusted.

Health Indicators

Moving the Dial

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DENVER HEALTH
Level One Care For ALL

Why PBHCI?

- Bringing primary care to people with SMI
- Strong primary care improves health outcomes, lower costs, and increases equity
- People with SMI die, on average, 25 years earlier than a healthy person

What does the PBHCI data tell us?

- Health Indicator data
- Are people getting better?
- Are there better practices to utilize?
- Telling the integration story
  - Congress Reviews– funding opps
  - What works/what doesn't?
- Help us identify best practices to encourage behavioral modifications

Value of Primary Care

- Place where patients can bring a wide range of problems
- Guides patients through the health care system
- Facilitates an ongoing relationship (continuity)
- Dealing with symptoms that are never attributed to a particular diagnosis
- Provides opportunities for disease prevention and health promotion

Moving the Dial

- Integrating primary care into behavioral health can help “move the dial” and allow people to live longer and healthier
- Evidence-based practices
- Data and importance of reassessment

Population Health

- What is population health and why is it important?
- Opportunities for grantees to monitor population health practices
- How is health improvement tracked over time?

Panel Management

Addressing the needs of the patients who walk through our door

Managing the care of ALL patients on our panels

- Better Health Outcomes
- Higher Patient Satisfaction
- Higher Provider & Staff Satisfaction
- Lower Costs

Who is your panel?

- The patient who walks through your door
- Any patient who has walked through your door in the last year
- The patient who identifies with you as being their primary care provider
- Any patient of your mental health center
- Any patient in your community with serious mental illness

Panel defined

Empaneled – patient with visit in last 18 months
Established – patient with visit in last 36 months

Primary Care at MHCD Patient Panel

by PCP

CHS Panel >> Medical Home

Provider	Total Panel		
BATAL, HOLLY	104	Clinical data	Contact info
GODDARD, SHANNON	409	Clinical data	Contact info
UNASSIGNED	69	Clinical data	Contact info
Total	582	Clinical data	Contact info

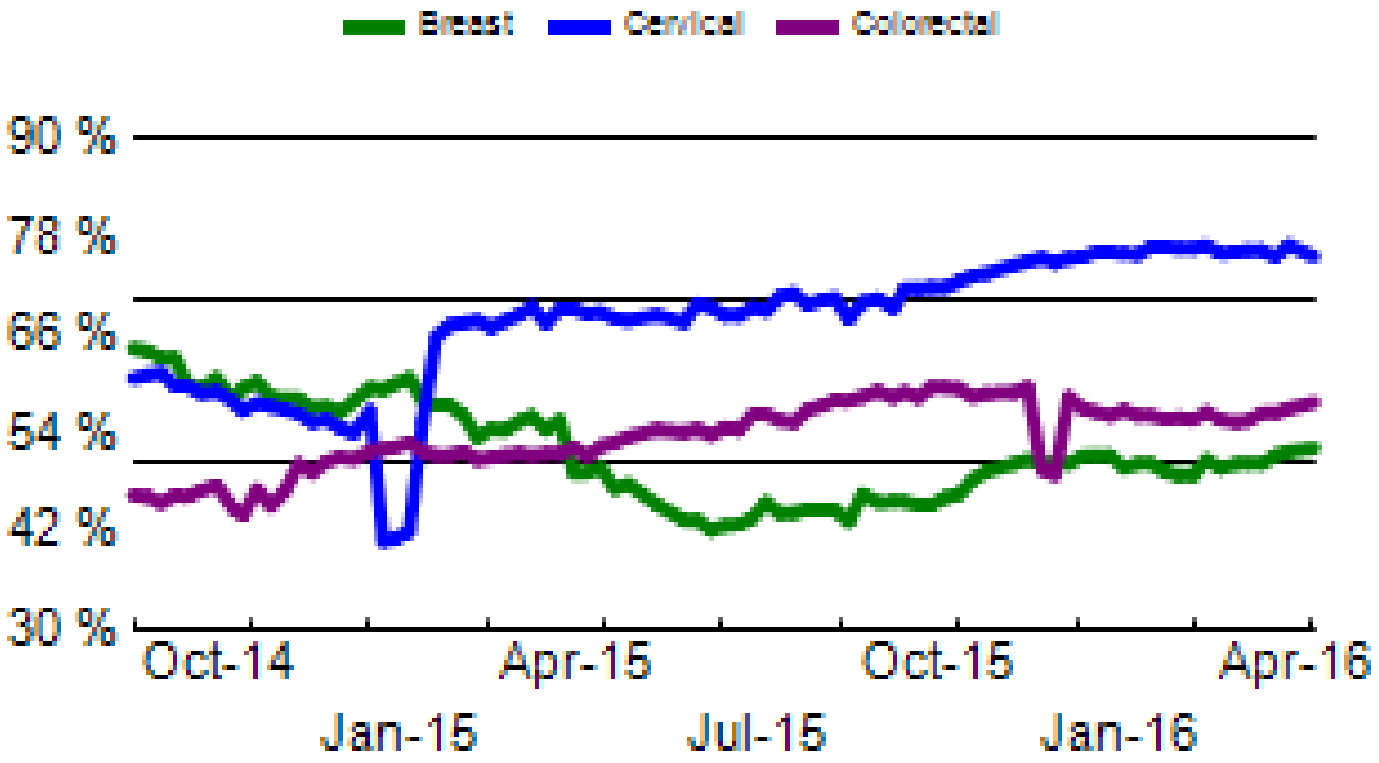
What health indicators should we track?

- Visit based: blood pressure, BMI, waist circumference
- Lab: hgba1c, lipids, urine microalbumin
- Cancer screening: cervical, breast, colon
- Health risks: obesity, tobacco abuse, alcohol abuse, exercise
- Social determinants: poverty, housing, social support
- Retention to care

Total clinic population

Latest metrics				Apr 9, 2016		
			Primary Care at MHCD			CHS
Registry	Measure	Target	Score	Denominator		Score
Diabetes	HgBA1c <=9%	70%	65 %	65		70 %
Diabetes	LDL <100 mg/dL	60%	51 %	65		34 %
Diabetes	BP <130/80	50%	62 %	65		44 %
Diabetes	Bundle 2/3 A1c, LDL & BP	50%	55 %	65		32 %
Hypertension	Controlled Blood Pressure	75%	68 %	162		66 %
Cancer Screening	Breast Cancer Screening	70%	52 %	104		61 %
Cancer Screening	Cervical Cancer Screening	85%	75 %	166		79 %
Cancer Screening	Colorectal Cancer Screening	65%	58 %	240		58 %

Cancer Screening



Provider specific measures

Primary Care at MHCD	Provider		Clinic		CHS	
	Pt N	Pct	Pt N	Pct	Pt N	Pct
Diabetes Care						
Hemoglobin A1c < 8	20	55%	65	58%	8632	56%
Hemoglobin A1c < 9	20	55%	65	60%	8632	69%
Blood Pressure < 140/90	20	85%	65	88%	8632	74%
Statin OK	20	85%	65	86%	8632	78%
3 out of 3 Bundle (A1c < 9)	20	50%	65	49%	8632	40%
Hypertension care						
Blood Pressure < 140/90	35	69%	162	66%	19,415	67%
Cancer Screening						
Colorectal Cancer	45	69%	238	57%	21,866	58%
Breast Cancer	23	65%	103	51%	12,106	61%
Cervical	33	88%	187	72%	35,417	76%
Pediatric Care						
Pediatric Immunizations	0	--	0	--	2,583	91%
Pediatric Well Child Care	0	--	0	--	2,581	73%
Adolescent Well Child Care	0	--	0	--	17,353	51%
Adolescent Tdap & MCV4	0	--	0	--	12,554	93%
Please see CHS OPPE for metric definitions						

Example – colorectal cancer screening

- Make the case – why is this important?
- Define population
- Define what counts as screened
- Visit based strategy vs panel based strategy
- Standard work – who does what when
- Know what to do when someone screens positive

Communication

- Share results regularly
- Data on both process measures and on outcomes
- Ask everyone (even patients) for ideas on how to improve
- Document processes and improvements
- Share improvements and failures with other clinics and sites

1 Meet with clinic leadership team

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Narrow in on population of focus with clinic leadership team:

- Review standard work for cervical & colorectal cancer screening, hypertension/CVD, and diabetes
- Review current performance metrics

Clinic team decides if PDSA continues, changes, or stops based on data. **Act** based on decision.

Cervical Cancer Screening		
		Tier 1 - Tier 4
	Activity	Due for Cervical Cancer Screening
Outside Records	Look in EDM to see if outside records for paps have been received, but not updated in LCR.	Centralized PN
Proactive Outreach	Identify patients overdue for Pap using C	
	Review LCR Patient Registry Summary to i	
	Call patient to ask them to come in for 1)	
	Contact Appt Center to schedule with Wo transportation.	
	Schedule patient for 1) Pap with PCP, 2) P	
	Mail Release of Information form to patie	
	Document patient outreach in PRM. Use t triggers.	
Pre-Visit Planning	Identify patients due for pap with an upc	
	Select Gaps in Care report	
	Call patient to remind her about about up screening; 2) Identify/address any barrie	
	Document patient outreach in PRM. Use t triggers.	
Day of PCP Visit	Huddle to scrub schedule. Print/review P	
Post Visit	Check to see if patient attended appointm	

Patients Needed to Get from Current Level (Red, Yellow, or Green) to Green Level - October 2015 - By "Region"

		Cervical Cancer	Breast Cancer	Colorectal Cancer	Diabetes A1c <=9	HTN BP Controlled	Total Pts
WEST	La Casa/Quigg Netwon	127	129	185	23	49	514
	Westwood	(22)	44	95	41	15	195
	Westside Adult	27	182	(16)	27	9	191
	Southwest (April 2016)	TBD	TBD	TBD	TBD	TBD	TBD
		155	355	280	91	73	899
CENTRAL & WOMEN'S CARE	Webb FIM	273	110	103	44	(14)	530
	Webb LOP	88	103	(23)	21	(5)	212
	Geriatric	-	72	132	(6)	53	257
	PAV C Women's Care	352	58	73	-	-	483
	Westside Women's Care	(8)	5	8	-	-	13
	Eastside Women's Care	39	3	5	-	-	47
		752	351	321	65	53	1,541
EAST	Lowry	202	163	110	17	243	736
	Montbello	44	9	61	31	38	184
	Eastside Adult	350	179	228	122	309	1,187
	Park Hill	186	98	194	4	113	595
	Primary Care at MHCD	18	21	14	4	10	66
		800	470	607	179	713	2,768
NOT COVERED	IOC	9	16	14	28	11	78
	HIV Primary Care	(4)	0	(12)	-	0	-

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Study the process, results, observations & share with clinic team

3

5

Do the PDSA, document data, clarify questions that arise

4

Pick a start date to **plan** PDSA, create data entry document, understand clinic-level processes

What's next? Improve something!

- Start small – start with data that you have
- Work at your team level, but align with funders, mental health center, etc
- Select one chronic conditions and/or one preventative health screening to work on
- Develop leading and lagging measures (data!)

Questions?

- Contact: Holly.Batal@dhha.org

QUALITY

THE RACE FOR QUALITY HAS NO FINISH LINE-
SO TECHNICALLY, IT'S MORE LIKE A DEATH MARCH.

Treatment Protocols

- Best practice approaches
- PCP discusses practical ways to follow protocols
  - Example

Treatment Adherence

- What treatment strategies are successful for people:
  - Living with SMI?
  - Who are homeless?
  - Others?
- Why is medication compliance important?
- How does having labs/pharmacy onsite make a difference?

Collecting and Monitoring Data

- What are we seeing from health indicator data?
  - Mathematica
- Importance of health indicator data
  - Evaluation of PBHCI
  - Integration of primary care into behavioral health settings